

UNIVERSITY OF CAMBRIDGE

ACCIDENT, DANGEROUS OCCURRENCE AND INCIDENT REPORT FORM

Give **as much information as possible**, - DSO to sign – send copy to the University Health and Safety Division

<p>A. Subject of Report <i>(Please tick box)</i></p> <p>1. Injury <input type="checkbox"/></p> <p>2. Dangerous occurrence <input type="checkbox"/></p> <p>3. Damage to equipment etc <input type="checkbox"/></p> <p>4. Accidents/Incidents with the potential to injure or cause damage <input type="checkbox"/></p> <p>5. Assault/Potential assault <input type="checkbox"/></p> <p>6. Health condition <input type="checkbox"/></p>	<p>B. Place, date and time</p> <p>Department/Institution</p> <p>Exact location of event</p> <p>If this area is constantly changing please provide a sketch plan in the space provided on Page 3.</p> <p>Name of Senior Staff responsible for the area</p> <p>.....</p> <p style="text-align: right;">Day of week Date Month Year Time</p>
---	--

C. Person injured or involved with incident			
Full Name		Age	
Prof/Dr/Mr/Mrs/Ms/Miss		M	F
Address			
Telephone No			

D. Occupation <i>(Please tick appropriate box)</i>			
Academic <input type="checkbox"/>	Catering <input type="checkbox"/>	Post Graduate - PhD <input type="checkbox"/>	
Academically related <input type="checkbox"/>	Farm workers <input type="checkbox"/>	Post Graduate - Post Doc <input type="checkbox"/>	
Technical - Laboratory ... <input type="checkbox"/>	Cleaning/domestic . <input type="checkbox"/>	Visitor <input type="checkbox"/>	
Technical - Workshops .. <input type="checkbox"/>	Portering <input type="checkbox"/>	Outside contractor <input type="checkbox"/>	
Secretarial/Clerical <input type="checkbox"/>	Security <input type="checkbox"/>	Work experience..... <input type="checkbox"/>	
Grounds/gardening <input type="checkbox"/>	Undergraduate <input type="checkbox"/>	Other <input type="checkbox"/>	
Further details			

E. Nature of injury <i>(Please tick appropriate box)</i>			
None <input type="checkbox"/>	Strain <input type="checkbox"/>	Bite <input type="checkbox"/>	
Cut <input type="checkbox"/>	Scratch <input type="checkbox"/>	Sting <input type="checkbox"/>	
Bruise <input type="checkbox"/>	Needlestick <input type="checkbox"/>	Electric shock <input type="checkbox"/>	
Fracture <input type="checkbox"/>	Foreign body <input type="checkbox"/>	Illness <input type="checkbox"/>	
Sprain <input type="checkbox"/>	Burn <input type="checkbox"/>	Radioactive contamination <input type="checkbox"/>	
		Other <input type="checkbox"/>	
Further details			

F. Regions of the body affected		<i>Indicate left (L) or right (R) where appropriate</i>			
	L/R		L/R		L/R
None..... <input type="checkbox"/>		Trunk <input type="checkbox"/>	<input type="checkbox"/>	Head <input type="checkbox"/>	<input type="checkbox"/>
Ear <input type="checkbox"/>	<input type="checkbox"/>	Eye <input type="checkbox"/>	<input type="checkbox"/>	Back <input type="checkbox"/>	<input type="checkbox"/>
Hand <input type="checkbox"/>	<input type="checkbox"/>	Finger <input type="checkbox"/>	<input type="checkbox"/>	Leg <input type="checkbox"/>	<input type="checkbox"/>
Foot <input type="checkbox"/>	<input type="checkbox"/>	Toe <input type="checkbox"/>	<input type="checkbox"/>	Face <input type="checkbox"/>	<input type="checkbox"/>
				Arm <input type="checkbox"/>	<input type="checkbox"/>
				Ankle <input type="checkbox"/>	<input type="checkbox"/>
				Other <input type="checkbox"/>	
Further details					

G. Cause

Slip, trip, fall on same level	<input type="checkbox"/>	Poisoning/infection ..	<input type="checkbox"/>	Hand tools	<input type="checkbox"/>
Falls on stairs	<input type="checkbox"/>	Animals	<input type="checkbox"/>	Hot/cold contact	<input type="checkbox"/>
Fall from height	<input type="checkbox"/>	Electricity	<input type="checkbox"/>	Sports	<input type="checkbox"/>
Machinery (moving parts)	<input type="checkbox"/>	Explosions	<input type="checkbox"/>	Traffic	<input type="checkbox"/>
Striking against object	<input type="checkbox"/>	Fire	<input type="checkbox"/>	Illness	<input type="checkbox"/>
Struck by object	<input type="checkbox"/>	Handling	<input type="checkbox"/>	Other	<input type="checkbox"/>
Spillages/releases	<input type="checkbox"/>	Glass/sharps	<input type="checkbox"/>		

Further details

H. Protective measures in use

Safety spectacles	<input type="checkbox"/>	Lab. Coat	<input type="checkbox"/>	Gloves	<input type="checkbox"/>
Fumecupboard	<input type="checkbox"/>	Guarding	<input type="checkbox"/>	Other	<input type="checkbox"/>

Further details

I. What happened?

Further details of accident/incident (include factors such as lighting, floor conditions, weather, etc. if relevant)

.....

.....

J. Treatment

Treatment given/action taken

.....

First aider attended [<i>Name</i>]	<input type="checkbox"/>	Casualty sent to Hospital	<input type="checkbox"/>
First aider not called	<input type="checkbox"/>	Casualty advised to see G.P.....	<input type="checkbox"/>
First aider not available	<input type="checkbox"/>	No injury incident	<input type="checkbox"/>

K. Likelihood of repeat

	<i>Frequent</i>	<i>Occasional</i>	<i>Rare</i> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	
Faulty/substandard equipment	<input type="checkbox"/>		Personal or job factors <input type="checkbox"/>
Faulty/substandard conditions	<input type="checkbox"/>		Unsafe conditions <input type="checkbox"/>
Failure to observe procedures	<input type="checkbox"/>		Environmental factors <input type="checkbox"/>

L. Name, address and telephone number of ALL witnesses

.....

.....

M. Action taken to prevent recurrence/make safe

.....

.....

Safety Officer: **BLOCK CAPITALS PLEASE**.....

Safety Officer Signature:Date

NB If no DSO, then authorised deputy; head of department; departmental administrator or person of similar standing.

Completing and signing this form does not constitute an admission of liability of any kind, either by the person making the report or any other person.

When completed send a COPY to the: University Health and Safety Division
20 Trumpington Street
Cambridge
CB2 1QA

The original must be kept in the department for at least 3 years.

Date entered in the departmental accident book

Sketch plan of area concerned (See B) (or attach separate sheet)

For Departmental Use

Follow up

- First Aid only
- G.P Visit
- Occupational Health Service days
- Hospital out-patient
- Detention in Hospital Days absent from/or unable to do normal work
- None/not applicable **NB** (inclusive of weekends, bank holidays, etc, as "over 3-day" accidents are reportable)

For University Health and Safety Division Use Only

Is Accident or Occurrence reportable under RIDDOR Yes No
If 'Yes' indicate category

- Fatality
- Major injury
- Public/Student to hospital
- Dangerous occurrence
- 24 hour hospital admittance
- Over 3 day injury

- Report sent to Insurance Officer
- Report sent to Occupational Health Service
- Details provided for UFSU.....
- F2508 Report sent to HSE (IO + OHS)

- Details provided for EMBS
- Details provided for CCFS
- Details provided for Union Representatives

- Copy for Biological Hazards Sub-committee 'box'
- Copy for Chemical Hazards Sub-committee 'box'
- Copy for Ionising and Non-Ionising Radiations Sub-committee 'box'

- Copy for Environmental Officer (EMBS).....
- Copy for School of Biological Sciences Safety Officer.....
- Copy for Clinical School Safety Officer.....

Request for further details; report asked for; visits made, etc

.....

.....

Any action taken to prevent recurrence

.....

.....

.....